## A. Introduction

As specified in HSS 107.16, Wis. Admin. Code, covered physical therapy services are defined as medically necessary evaluations, modalities, and procedures prescribed by a physician. Refer to HSS 101.03 (96m), Wis. Admin. Code, for the definition of "medically necessary." The services must be performed by one of the following:

- ✓ Certified PT.
- ✓ Certified physical therapy assistant (PTA) under the direct (on premise) supervision of a PT.
- ✓ Physical therapy aide for specific services and when specific supervisory requirements are met (refer to Section II-E of this handbook for more information).

Services that do not require the skills of a PT (e.g., nursing services, active treatment services, activity services, and caregiver services) are not covered.

## B. Covered Services

### Evaluations

An *evaluation* consists of one or more tests or measures used to assess a recipient's needs. Evaluations are not paid when provided by a PTA or physical therapy aide. Refer to Appendix 6 of this handbook for a listing of types of covered evaluation services.

Evaluation days are, from a prior authorization threshold standpoint, considered treatment days and are counted toward the 35 treatment days within a spell of illness.

### Therapy Evaluations in Facilities for the Developmentally Disabled

In most situations, a full professional evaluation by a therapy professional is *not* required annually for residents in a Facility for the Developmentally Disabled (FDD). Federal regulations require that the comprehensive assessment is reviewed at least annually for each resident in a FDD or Intermediate Care Facility for the Mentally Retarded (ICF-MR). Federal regulations [Interpretive Guidelines - Intermediate Care Facilities for the Mentally Retarded; Health Care Financing Administration Federal Regulations: State Operations Manual 212 483.440 (c) (3) (v)] require the facility to assess developmental *areas*, but *not* by professional disciplines unless the functional assessment shows a need for a full professional evaluation.

A physical therapy evaluation by a therapy professional must specify the recipient's current level of functioning and include one of the following:

- ✓ Specific recommendations for a therapy program, including measurable treatment goals.
- ✓ Specific current recommendations for active treatment, including specific instructions for other treatment staff.

Therapy evaluations in FDDs are subject to the spell of illness (SOI), prior authorization, daily duration, and other limitations referred to under HSS 107.16, Wis. Admin. Code. This applies to comprehensive therapy evaluations by independent and rehabilitation agency providers.

### Modality

A *modality* consists of a treatment involving physical therapy equipment or apparatus which does not require the PT's personal continuous attendance when in use, but does require setting up, frequent observations, and evaluation of the treated body part before and after treatment. Refer to Appendix 7 of this handbook for a list of modalities.

**B. Covered Services** (continued)

**Procedure**

A *procedure* consists of a treatment (with or without equipment or apparatus) which requires the PT's personal continuous attendance. Refer to Appendix 8 of this handbook for a list of covered procedures.

*Electrical Stimulation*

Electrical stimulation for pressure sore treatment is covered only for stages III and IV pressure sores. Services must be performed under a PT's direct supervision.

**C. Plan of Care**

As specified in HSS 107.16, Wis. Admin. Code, a physician must prescribe (sign and date) or co-sign orders for physical therapy services for Medicaid coverage of the service. Therapists may document a physician's verbal order and then obtain the physician's signature and date.

A plan of care must be established and reduced to written form. As specified in HSS 107.16 (3) (a) 2, Wis. Admin. Code, the physician must review the plan of care in consultation with the provider. Reviews must occur at intervals required by the severity of the recipient's condition, but at least every 90 days. The plan of care may become the prescription when signed and dated by the physician. The provider must retain the plan of care in the recipient's permanent record.

The plan of care must include all of the following:

- ✓ The type, amount, frequency, and duration of the therapy services.
- ✓ All evaluations or results of current status reports that justify the plan of care.
- ✓ The diagnosis, a functional evaluation, and anticipated goals.

Changes to the plan, per the attending physician's verbal orders, must be in writing and signed and dated by the physician and the therapy provider.

**D. Daily Service Limitations**

**Ninety-Minute Daily Coverage Limitations**

As specified in HSS 101.03 (96m) and HSS 107.02 (2) (b), Wis. Admin. Code, Wisconsin Medicaid does not cover physical therapy services beyond 90 minutes per day unless coverage of additional medically necessary treatment is requested and approved through the claims adjustment process (see next paragraph). This limit is based on the determination that physical therapy services in excess of 90 minutes per day generally exceeds the medically necessary, reasonable, and appropriate duration of physical therapy services.

If, under extraordinary circumstances, physical therapy treatment is necessary beyond the limitation of 90 minutes per day, coverage of additional treatment time may be requested by submitting an adjustment request form after the claim is paid. The specific medical reason for exceeding the 90-minute limitation must be documented on the adjustment request form. Refer to Section X and Appendices 27 and 27a of Part A, the all-provider handbook, for information on submitting an adjustment request.

**Daily Unit of Service Limitation**

Wisconsin Medicaid covers some procedure codes only a limited number of times a day. Refer to 'Daily Unit of Service Limit' in Appendix 4 of this handbook for specific limits.

**E. Allowed Procedures for PTAs**

PTAs may not perform some Medicaid procedures such as evaluations. Refer to Appendix 4 for the procedure codes PTAs may perform.

## F. Physical Therapy Aide Services

As specified in HSS 107.16 (1) (e), Wis. Admin. Code, physical therapy aides must be trained in a manner appropriate to their job duties. Clinical services that exceed a physical therapy aide's competence, education, training, and experience are not payable. Physical therapy aide services must be provided under the direct, immediate, on-premise supervision of a PT. The PT-to-physical therapy aide ratio must be 1:1 for billable services, except as noted in the next two paragraphs.

As specified in HSS 107.16 (1) (e), Wis. Admin. Code, the Department of Health and Family Services (DHFS) may exempt a facility providing physical therapy services from the supervision requirement if it determines that direct, immediate, one-to-one supervision is not required for specific assignments which physical therapy aides are performing at that facility.

For example, facilities providing significant amounts of hydrotherapy may be eligible for an exemption for physical therapy aides who fill or clean tubs. If an exemption is granted, the DHFS indicates the specific physical therapy aide services for which the exemption is granted and sets a supervision ratio appropriate for those services. Refer to HSS 106.13, Wis. Admin. Code, for more details on waiver requirements.

Physical therapy aides are not paid directly for their services.

As specified in HSS 107.16 (1) (e), Wis. Admin. Code, the following physical therapy aide services may be provided:

- ✓ Performing simple activities required to prepare a recipient for treatment, assisting in the performance of treatment, or assisting at the conclusion of treatment (such as helping the recipient to dress or undress, transferring a recipient to or from a mat, and applying or removing orthopedic devices).
- ✓ Assembling and disassembling equipment and accessories in preparation for treatment or after treatment has taken place.
- ✓ Assisting with the use of equipment and performing simple modalities once the recipient's program has been established and the recipient's response to the equipment is highly predictable.
- ✓ Providing protective assistance during exercise, activities of daily living, and ambulation activities related to the development of strength and refinement of activity.

## G. Spell of Illness (SOI)

### Definition

As specified in HSS 107.16 (1) (2) (a) through (e), Wis. Admin. Code, a "spell of illness" is a documented condition in which a recipient has a loss of functional ability to perform daily living skills. This loss of functional ability may be caused by a new disease, injury, medical condition, or by increased severity of a pre-existing medical condition.

### Documenting an SOI

As specified in HSS 107.16 (2) (c), Wis. Admin. Code, the provider must document an SOI in the patient's plan of care, including all of the following:

- ✓ Measurable evidence that the recipient has incurred a demonstrated functional loss of ability to perform daily living skills.
- ✓ Has the potential to achieve his/her previous level of functional ability.

G. **Spell of Illness (SOI)** (continued)

### When an SOI Begins

An SOI begins with the first day of treatment or evaluation following the onset of a new disease, injury, medical condition, or increased severity of a pre-existing medical condition.

### The Recipient's First SOI

A recipient's first SOI is the first time the recipient requires therapy in their lifetime.

### Treatment Days Allowed Within an SOI

Up to 35 treatment days are allowed per SOI. The 35 treatment days include all of the following:

- ✓ Evaluations.
- ✓ Treatment days covered by Medicare or health insurance.
- ✓ Treatment days provided by another provider, in any outpatient setting.

Unused treatment days from one SOI cannot be carried over into a new SOI. When a new authorized SOI occurs within the current SOI, the old (current) SOI stops, and a new SOI begins. The new authorized SOI has 35 treatment days. Prior authorization must be obtained for continued physical therapy services beyond the SOI.

### When an SOI Ends

An SOI ends when the recipient's condition improves so that the services of a PT are no longer required or after 35 treatment days, whichever comes first.

### Approval Process for an SOI

The recipient's first SOI in their lifetime does not need prior approval for payment of medically necessary services. After the first SOI, all additional SOIs require approval for payment by submitting a "Prior Authorization Spell of Illness Attachment" (PA/SOIA) and "Prior Authorization Request Form" (PA/RF) as soon as possible before billing for services.

Appendices 11 through 13 of this handbook contain instructions for submitting documentation for second and subsequent SOIs. The "Spell of Illness Guide" in Appendix 13 of this handbook further clarifies the SOI procedure.

### Approval Criteria for a New SOI

As specified in HSS 107.16 (2) (a), (b), and (c), Wis. Admin. Code, to consider a condition as a new SOI, recipients must display the potential to reachieve the previously attained level of independence exhibited immediately before the onset of the SOI.

The following conditions may justify a new SOI:

- ✓ An acute onset of a new disease, injury, or condition such as one of the following:
  - → Neuromuscular dysfunction, including stroke-hemiparesis, multiple sclerosis, Parkinson's disease, and diabetic neuropathy.
  - → Musculoskeletal dysfunction, including fracture, amputation, strains and sprains, and complications associated with surgical procedures.
  - → Problems and complications associated with physiologic dysfunction, including severe pain, vascular conditions, and cardio-pulmonary conditions.

**G. Spell of Illness (SOI)** (continued)

- ✓ An exacerbation of a pre-existing condition, including but not limited to the following, which requires physical therapy intervention on an intensive basis such as one of the following:
  - → Multiple sclerosis.
  - → Rheumatoid arthritis.
  - → Parkinson's disease.
- ✓ A regression in the recipient's condition, due to a lack of physical therapy, as indicated by a decrease of functional ability, strength, mobility, or motion.

**Services in Excess of 35 Treatment Days per SOI**
Prior authorization is required for physical therapy services in excess of 35 treatment days for conditions that do not qualify for a new SOI.

**H. Additional Requirements**

**Coverage of Treatment for Conditions That Never Qualify for an SOI**
Certain conditions never qualify for an SOI such as decubitus ulcers and mental retardation.

For conditions that do not qualify for an SOI and for certain other procedures, prior authorization is required starting with the first day of treatment. Refer to Section III of this handbook for more information.

**Co-Treatment (Interdisciplinary Treatment)**
Co-treatment is covered only when medically necessary. Co-treatment is simultaneous treatment by two different therapy providers at the same time period, (e.g., by speech pathology and occupational therapy, or physical therapy and occupational therapy). Co-treatment may be requested when the unique treatment approach offered by multiple therapies during the same treatment session is medically necessary to optimize the recipient's rehabilitation. Refer to Section III of this handbook for more information.

**Duplicate Services**
As specified in HSS 101.03 (96m), Wis. Admin. Code, Wisconsin Medicaid does not cover duplicate services provided to recipients who have received physical therapy services from another certified provider. Before beginning evaluations or therapy, providers are advised to request prior authorization. For example, Wisconsin Medicaid may deny payment when another provider had a valid prior authorization for therapy services or when prior payment for physical therapy services has been received by another provider under a recipient's first or subsequent SOI.

**Preventive/Maintenance Therapy Services**
As specified in HSS 107.16 (3) (c), Wis. Admin. Code, Wisconsin Medicaid covers preventive/maintenance therapy services when one or more of the following conditions are met:

- ✓ The skills and training of a therapist are required to execute the entire preventive and maintenance program (e.g., there is no one else qualified to provide the level of care required).
- ✓ The specialized knowledge and judgment of a PT are required to establish and monitor the therapy program including the following:

**H. Additional Requirements** (continued)

- → The initial evaluation.
- → The design of the appropriate program.
- → The instruction of nursing personnel, family, caregiver, or recipient.
- → The required re-evaluations.

✓ The nursing personnel cannot handle the recipient safely and effectively due to the severity or complexity of the recipient's condition.

**I. Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS)**

Durable medical equipment (DME) are medically necessary devices that can withstand repeated use. DME primarily serve a medical purpose and are generally not useful to a person without an illness or injury. All items must be appropriate for use in the recipient's place of residence.

DME are covered only when prescribed by a physician and listed as covered services in the Wisconsin DME Index for therapy providers. Refer to the DME and DMS handbook (Part N) for more information.

Wisconsin Medicaid may cover medically necessary DMS used during the course of treatment. Refer to the DMS Index for a list of covered DMS.

**J. Communication with Other Medicaid Providers**

When a recipient receives similar Medicaid services from therapists and other providers, these providers *must* communicate with each other for the following reasons:

- ✓ To ensure service coordination.
- ✓ To avoid duplication of services.
- ✓ To facilitate continuity of care.

*Note:* Other Medicaid providers are Medicaid HMOs and fee-for-service providers including other therapists, school-based services (SBS) providers, physician clinics, rehabilitation agencies, local health departments, community mental health agencies, tribal health agencies, and home care agencies.

When a recipient receives services from both SBS and non-SBS therapists, documented communication must occur at least annually. The communication must be documented in the recipient's medical records.

*Note:* SBS providers are required to cooperate with Medicaid fee-for-service providers who request copies of the child's IEP/IFSP or components of the multi-disciplinary team (M-team) evaluation.

**K. Noncovered Services**

As specified in HSS 107.16 (4), Wis. Admin. Code, Wisconsin Medicaid does not cover the following physical therapy services:

- ✓ Services related to activities for the general good and welfare of recipients include the following:
  - → General exercises to promote overall fitness and flexibility.
  - → Activities to provide diversion or general motivation.
- ✓ Those services that can be performed by restorative nursing, as specified in HSS 132.60 (1) (b) through (d), Wis. Admin. Code.

**K. Noncovered Services** (continued)

- ✓ Activities such as end-of-the-day clean-up time, transportation time, consultations and required paper reports (these are considered components of the provider's overhead costs and are not separately reimbursable).
- ✓ Group physical therapy services.
- ✓ Activities performed by a physical therapy aide including the following:
  - → Interpretation of physician referrals.
  - → Patient evaluation.
  - → Evaluation of procedures.
  - → Initiation or adjustment of treatment.
  - → Assumption of responsibility for planning recipient care.
  - → Making entries in recipient records.

As specified in HSS 107.02 (2), Wis. Admin. Code, services which require prior authorization but have not been approved are noncovered services.

As specified in HSS 101.03 (96m), Wis. Admin. Code, services determined by Wisconsin Medicaid as not medically necessary and/or experimental are noncovered services. This includes the following noncovered services:

- ✓ *Facilitated Communication (FC)* - This service is noted as experimental by the American Speech-Language-Hearing Association in ASHA, March 1995. The American Psychological Association, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the American Association on Mental Retardation concur in policy statements developed in 1993 and 1994.
- ✓ *Auditory Integration Therapy (AIT)* - This service is noted as experimental by the American Speech-Language-Hearing Association in ASHA, November 1994, and the American Academy of Audiology in Audiology Today, July-August 1993.

As specified in HSS 107.16, Wis. Admin. Code, services that can be performed by nursing, active treatment, activity, and caregiver services are noncovered services under Medicaid's therapy benefit.